

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036150

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

SL 20480

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9007

1. DATE OF DEATH
a. COUNTY

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN 915 N. GRAND, ST. LOUIS, MO.Length of stay in 1b
16 DAYSc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION VET. ADM. HOSPITALInside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY SAINT LOUISc. CITY
OR
TOWN DELLWOOD, SInside Limits
Yes ☒ No ☐d. STREET
ADDRESS 10024 VENTURA DR.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

PATRICK

FLYNN

4. DATE
OF
DEATH

Month

Day

Year

SEPTEMBER

17

1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

4/20/90

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

IRELAND

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

MICHAEL FLYNN

13b. MOTHER'S MAIDEN NAME

MARY O'LEARY

14. NAME OF HUSBAND OR WIFE

- - - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)
YES WW-1

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

A MARGARET TUCKER (SISTER), SAME ADD. AS 2

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

SHOCK

DUE TO (b)

GRAN NEGATIVE BACTERIAL SEPTICEMIA

DUE TO (c)

PYELONEPHRITIS

6000

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes☐ No☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

9/1/62

to 9/17/62

and last saw him alive on

9/17/62

Death occurred at

4:30 A. M.

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

VAH, ST. LOUIS, MO.

22c. DATE SIGNED

9/17/62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE

9-19-62

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis, Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

Calvin F. Feutz 4828 Natural Bridge Blvd.

25. DATE RECD. BY LOCAL REG.

SEP 18 1962

26. REGISTRAR'S SIGNATURE

Karl Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert E. Mulhman

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.